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CHANGING ROLES OF INSTITUTIONAL TREATMENT IN MASSACHUSETTS 1970 - 1981

IMPLICATIONS FOR STAFFING POLICIES

OFFICE OF STAFF TRAINING

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FOREWORD

In 1966, the General Court of the Commonwealth of Massachusetts enacted the Comprehensive Mental Health and Mental Retardation Act. The purpose of this act was to decentralize the Department of Mental heath and set up a network of services within each community so that services can be delivered to clients without removing them from the communities in which they live. It established the Area service system we know today.

An important component of this Act was the phasing down of the large state hospitals, which by the mid-1950's were warehousing tens of thousands of patients. In 1971, Massachusetts closed its first state hospital. By 1981, it had closed four and significantly reduced the size of the seven that remained.

Closing, or significantly scaling down, a large institution is a major event. It impacts heavily on the nature of the treatment system, clients, staff, and the neighboring communities. In Massachusetts, the closing of hospitals took place in an ideological climate that contributed heavily to the decision making process. Massachusetts became a national leader in developing community services and scaling down services delivered in large institutions.

It is important to study this process, to understand its successes and recognize its shortcomings. While it did change the nature of the service system in the direction of comprehensive community services, there were costs to be paid. Overoptimistic projections of census reduction left the hospitals with inadequate resources and the remaining patients with inadequate care. In addition, the flow of resources to the community never did meet the expectations of community managers.

Perhaps most importantly, the hospitals remained impoverished for the decade following this movement. In that time, substantial deterioration, both of physical plants and services, took place. Massachusetts now finds itself in the position of committing substantial resources to the hospitals in order to recertify the beds and create acceptable treatment environments.

The great benefit of this process for Massachusetts is that it has enabled to Department to re-evaluate the role of inpatient services. Massachusetts is developing a well articulated model of the Balanced Service System which is based on high quality inpatient services working hand in hand with high quality community services. It is this vision which drives the Massachusetts service system today.

INTRODUCTION

Across the United States, there has been, and continues to be, a strong movement of deinstitutionalization which involves phasing down state operated psyvchiatric hospitals. In most, if not all, cases, there is a strong expectation of reallocating significant resources to community programs.

Massachusetts has been a national leader in this process. The experiences of Massachusetts in redeploying hospital staff to community programs are described in this paper. It is hoped that this experience can be generalized and made useful to other states.

This paper reviews, in some detail, the Massachusetts experience with hospital closings and related hospital staffing reallocations. A case study format is used to organize the different staffing reallocations that took place. Generalizations are drawn from these experiences, and available studies and data are reviewed. The result is a set of recommendations and policy implications which may be useful to other states.

Historically, Massachusetts has been a national leader in the provision of services to the mentally ill. This leadership role can be traced to the essential roots of care as we know it for the mentally ill and continues at the present time. It is important to understand hospital closings in the context of these roots.

The paper begins with a historical overview of mental health care in Massachusetts. More comprehensive reviews can be found in a variety of documents. The interested reader is particularly referred to Mental Health Crossroads (DMH, 1981) and Mary Remar's papers (e. g., 1973).

The next section presents a series of case studies of facility staffing reallocations in some detail. These case studies include hospital closings and the shifting of institutional resources to community settings.

To assist the reader in comprehending the scale of these operations, each hospital is described in terms of the census, or number of patients in residence. The peak census is given (during the mid-1950's) to show how large the hospital had become. The census is also given for two important years. In 1966, the General Court of Massachusetts enacted the Comprehensive mental Health and Mental Retardation Act to establish a network of services within each community. This act established the Catchment Areas, Regions, Area Boards, and local programs that are the hear t of the current service system. In 1971, the Department

published a five year progress report on the act, entitled Challenge and Response.

Finally, a series of generalizations are drawn from the historical documentation and available research studies. These are presented in a format which will hopefully be useful to other states planning similar endeavors and facing the same policy decisions.

The events described in this paper took place generally during the decade of the 70's. Several important changes have taken place since then, most notably the reversal of the previous policies of using hospital resources to staff community programs. In Massachusetts, the state hospitals are now being revitalized and resources added to them. This does not signify a return to the old institution-dominated treatment system. Instead, it acknowledges the importance of high quality inpatient care in the Balanced Service System. Because the hospitals had deteriorated to a substandard state, significant resources are required to make them acceptable.

The events described in this paper were important and changed the face of the service system in Massachusetts. It is important to study the successes and failures of these events, and to recognize that change continues to occur.

A. HISTORY OF MENTAL HEALTH SERVICES IN MASSACHUSETTS

In the 17th and 18th centuries, as population densities increased due to urbanization, the public became more concerned with deviant behavior. As one of the first formal means of dealing with social problems in the United States, almshouses were established in urban centers to care for the needy. Almshouses provided shelter for a wide range of indigent people, including paupers, widows, orphans, and those unable to care for themselves, such as the insane. The history of Massachusetts' concern for the dependent began with the opening of the first American almshouse in Boston, in 1662, which provided cost-efficient shelter for people with public welfare needs.

Toward the end of the 18th century, the heterogeneity and overcrowding of the almshouses spurred the development of urban hospitals. These isolated the physically and mentally ill persons from the remainder of the almshouses populations, such as criminals, vagrants, widows, orphans and the elderly. In 1729, Boston was among the first locations to call for the establishment of separate care and housing for the emotionally disabled.

In 1764, Thomas Hancock, uncle of John Hancock and builder and first resident of the Governor's mansion on Beacon Hill, made the following bequeathment:

> "I give unto the town of Boston the sum of six hundred pounds lawful money towards erecting and finishing a convenient house for the reception and more comfortable keeping of such unhappy persons as it shall please God, in his providence, to deprive of their reason in any part of this Province; such as are inhabitants of Boston always to have the preference." (Briggs, 1916)

However, the legacy was declined by the Selectmen of the City of Boston. They did not consider that there were enough mentally ill persons in the Province for them to erect such a house.

It was not until 1811 that the General Court established the Massachusetts General Hospital and the McLean Asylum. These were supported primarily through private philanthropy and sliding fee scales. McLean, originally established to care for the indigent mentally ill, eventually erected highly exclusive admission policies based on patients' ability to pay. Through the early 1830's, almshouses and jails remained the locus of care for the majority of poor, emotionally disabled people.

While the number of private hospitals grew throughout America, they could not keep pace with needs in the first half of the nineteenth century. The forces of urbanization and

immigration swelled the almshouse population and stressed municipalities. At the same time, two ideological movements created a concerted public response to mental illness: a belief in institutional shelter for dependent and deviant people and the first real theory of care for mental illness, termed "moral treatment." Thus the concept of the insane asylum was born.

The work of Philippe Pinel in France and others was demonstrating that mental illness was not caused by supernatural forces nor was it incurable. Pinel's approach to therapy, which became known as "moral treatment," consisted of gaining the patient's confidence and instilling a sense of hope. It involved creating a total therapeutic environment of social, psychological, and physical factors. Thus it placed great emphasis on providing mentally ill persons with a new environment in order to control the influence of the environment over the person's mental state.

Once again, Massachusetts led the nation in the revolution of care for the disabled. In 1833, Massachusetts established one of the first public psychiatric hospitals in the country, the State Lunatic Hospital at Worcester, now known as Worcester State Hospital. It established a comprehensive hospital system based on the therapeutic principles of moral treatment, and was open to all regardless of social or economic class. This became the prototype for other states to follow. Previous to that time, most of the insane were confined to jails, houses of correction, or almshouses, living under conditions that almost defy imagination. While a number of private and public institutions had been founded after the war of 1812, they were small and generally catered to the upper- and middle-class patients that could pay for their upkeep.

To keep pace with urban needs, the Boston Lunatic Asylum emerged in 1839 as the first municipal mental hospital. However, in only a few years, this facility was also filled beyond its intended capacity. Now known as Boston State Hospital, this institution has a rich history that reflects the history of treatment of mental illness.

In the mid to late nineteenth century, state mental hospital development was greatly aided by the efforts of the great reformer from Massachusetts, Dorothea Dix. Her crusade for expanded moral treatment began at Worcester State Hospital in 1841. By the 1860's, Massachusetts had three state mental hospitals (Worcester, Taunton, and Northampton), one municipal hospital (Boston Lunatic Asylum), and 219 almshouses.

However, the demand for services far outstripped the capacities of the available facilities. By the late nineteenth century, spurred by waves of destitute immigrants and the effects of urbanization and industrialization, public care was overwhelmed

by overcrowding, low funding, cultural differences, and societal criticism. In 1863, Massachusetts established the first state welfare department, the Board of State Charities, to manage public programs for the indigent, which included mental health care.

By 1875, there were six public and private mental institutions in Massachusetts with a total census of over 2,000. This marked the beginning of a period of proliferation of institutional care and deteriorating treatment, as the state built more mental hospitals to warehouse the mentally ill.

The Special Report of the State Board of Insanity to the Legislature of 1900 described "A General System of Care" for all the insane requiring public supervision. The units of this system were described as:

1. "The hospital, which receives directly from the courts all classes of the insane, both recoverable and chronic.

2. "The asylum, which receives only from the hospitals transfers of chronic cases.

"Thus is recognized the principle of separation of the acute and curable from the chronic. This principle should be dominant in all future extensions."

This report also described the concept of the colony, which accepts overflow populations from the asylums:

3. "The colony for the chronic insane of the above classes may be outlined thus:-

"It should start with a farm of not less than two thousand acres, near good railroad facilities. The land may be rough, hilly and stony, but should ultimately become fertile, when brought under cultivation by the labor of patients. There should be plenty of growing timber and wood, clay beds for brick making, a quarry for stone cutting, water power, and other natural advantages for the formation of a village community."

By the early twentieth century, Massachusetts had built several institutions. These are briefly noted below:

1833 Worcester State Hospital
Established as the State Lunatic Hospital at Worcester, this facility merits special attention because of the influential historical role it has played in the treatment of mental illness.

1839 Boston State Hospital
This facility was established as the Boston Lunatic Asylum.

1854 Taunton State Hospital

1858 Northampton State Hospital
Established as the Northampton Lunatic Hospital, this facility is the center of the Brewster vs. Dukakis Consent Decree.

1866 Tewksbury State Hospital
Tewksbury Insane Asylum was originally founded to care for patients with tertiary syphilis and Korsakoff's syndrome. It is now a public health facility.

1877 Grafton State Hospital
Orignially called the Grafton Colony, this facility was designed as the overflow colony for Worcester State Hospital.

1878 Danvers State Hospital
The Danvers Lunatic Hospital was built to take the overflow from Boston State Hospital and the Tewksbury Insane Asylum.

1886 Westboro State Hospital
Westboro State Hospital was founded specifically for those patients and their families who believed in homeopathic forms of treatment, based on the principles introduced by Dr. S. C. F. Hahnemann of Philadelphia.

1893 Foxborough State Hospital
Originally established as a special facility for the treatment of "Dipsomaniacs and Inebriates," the facility became a hospital for the insane in 1905.

1896 Medfield State Hospital

1898 Monson State Hospital
Monson was established as The Hospital For Epileptics. With the advent of treatment for epilepsy, the census was reduced to a resident population with multiple handicaps, primarily brain damage and mental retardation. It became Monson Rehabilitation Center, under the Division of Mental Retardation, fairly recently.

1902 Gardner State Hospital
Gardner was established as The State Colony, an overflow colony for Worcester State Hospital.

1909 Boston Psychopathic Hospital
Opened in conjunction with the Harvard Medical School, the "Boston Psycho" provided research and training for psychiatrists and an aggressive aftercare program, blending research and treatment. It later became the Mass Mental Health Center.

In spite of the aggressive building of facilities by the Commonwealth, need continued to outpace available services. Most noticeably from waves of destitute immigrants, mental health facilities were taxed beyond their limits. Treatment became impossible, living conditions deplorable, and the demand continued to grow from year to year. Twenty percent of the insane in state institutions were in temporary beds in corridors and day rooms.

The fifth annual report of the State Board of Insanity to the Legislature (1903) noted that:

> "Overcrowding in public hospitals and asylums continues to be extreme, necessitating the use of 1,733 beds in corridors and day rooms, of which 1,051 are removed each morning to make sufficient day space for patients."

The report further noted that:

> "It is fair to accept the average annual increment during the last five years - nearly 400 - as the present annual rate of accumulation of the insane, for whom public attention is required."

Another wave of change did not sweep Massachusetts until after World War II. The Great Depression and the costs of the war had undercut the funding and manpower of the institutions, creating abysmal conditions. Prior to the advent of psychotropic medications and the ideology of community care, the Massachusetts inpatient facilities reached a peak census in the 1950's of over 23,000. In addition to thirteen state operated facilities, the state also provided inpatient care to mentally ill offenders at Bridgewater State Hospital and elderly people at Cushing Hospital.

Even at this time of institutional treatment, Massachusetts was developing community based services. In addition to 36 child guidance clinics and a small number of court clinics, there was an acute receiving hospital, the Boston Psychopathic Hospital. The "Boston Psycho" was established by L. Vernon Briggs in 1909, who

fought for and won the acquisition of the land adjacent to the Harvard Medical School to build a general hospital for psychiatry, including an outpatient department to facilitate early discharge and aftercare. Fifty six years later, this became the Massachusetts Mental Health Center, the first community mental health center in the nation. From its inception, the contributions of this facility to community psychiatry have been many and significant.

B. STATE OVERSIGHT

As concepts of mental illness and treatment changed over the years, the role of the state in managing these services also changed. The nature of these changes is exemplified in the titles of the state agencies over the years. The following table shows the state agency providing oversight for the treatment of mental illness.

In the beginning, institutions were overseen by Boards of State Charities, which had responsibilities for hospitals for the insane, almshouses, workhouses, state farms, schools for idiots and the feebleminded, reformatory institutions, and general hospitals.

1863	Affairs were complex enough to hire an Executive Secretary and General Agent.
1879	Chapter 291 of the Laws of 1879 contained "An Act to Create a State Board of Health, Lunacy, and Charity."
1886	Chapter 101 established a State Board of Health . separate from Lunacy and Charity.
1898	Lunacy became officially known as insanity. Chapter 433 created the State Board of Insanity.
1909	The state assumed all responsibility for operating facilities for the insane. Chapter 504 stated:

The care, control and treatment of all insane, feeble-minded and epileptic persons, and of persons addicted to the intemperate use of narcotics or stimulants, the care of whom is vested in the commonwealth by the provision of law in force on the date of passage of this act...No county, city or town shall establish or maintain any such institution or receptacle, or be liable for the

board, care, treatment or act of any inmate thereof.

1916 Chapter 285 abolished the State Board of Insanity and established the Massachusetts Commission on Mental Diseases.

1919 Chapter 350 changed the name to the Department of Mental Diseases, as a part of a reorganization of over 100 state departments into 20 divisions.

1938 Chapter 486 changed the name to the Department of Mental Health, and provided for major reorganizations.

During this time, the central office of the Department of Mental Health provided some management and policy, but the superintendents of the state hospitals were largely autonomous and their facilities were virtually the only available resource for those mentally ill people unable to purchase private care.

C. DEINSTITUTIONALIZATION IN MASSACHUSETTS

Following the publication of Action for Mental Health by the federal Joint Commission on Mental Health in 1961 and the passage of the federal Community Mental Health Center Act in 1963, Massachusetts created the Mental Health Planning Project. Its findings were published in 1965 in the report Mental Health in Massachusetts. The report called for the implementation of a network of community mental health centers and decreased reliance on mental hospitals. Chapters 735 and 123 of the Massachusetts General Laws, in 1966 and 1970, translated these goals into state law and formed the basis of the public mental health system as it now exists.

In the early 1970's, Massachusetts again became a national leader in the mental health field with its commitment to deinstitutionalization. Between the 1950's and the early 1980's, the hospital census decreased by more than a factor of ten, from well over 20,000 to just over 2,000. In 1973, Massachusetts signaled its commitment to deinstitutionalized mental health care by closing Grafton State Hospital. This was one of the first mental hospitals in the nation to be closed. In the next eight years, three other state hospitals were closed: Foxborough State Hospital in October of 1975, Gardner State Hospital in June of 1976, and Boston State Hospital in 1981. In addition, staff were redeployed from the state hospitals to community programs throughout the state, as staffing patterns reflected the large

drops in patient populations and community services were developed.

An examination of hospital budgets in Massachusetts compared to other states vividly illustrates the fiscal effects of deinstitutionalization. In FY '76, for example, Massachusetts hospitals' per capita expenditures were $13.68, which was very close to the average of $13.83 for eastern states. In 1980, however, Massachusetts' expenditures had dropped to $10.78, while the average among eastern states had risen to $18.74.

The effects of deinstitutionalization on patients are well known and widely discussed. The effect of deinstitutionalization on staff, however, has been less thoroughly researched. Unions were generally against hospital closings or cutbacks, fearing that this would result in layoffs of transfers (AFSCME, 1975). In many towns, the state hospital was a primary employer. Thus closings and cut backs not only increased unemployment but they also decreased demand for many local goods and services (Morrissey, Goldman and Klerman, 1980:6).

In 1973, some 9,000 persons were employed in ten state hospitals in Massachusetts. Four hospitals were closed, with varying levels of staff redeployment. Currently, less than 5,000 state employees work in all inpatient settings, including Community Mental Health Center inpatient units and speciality hospitals (Gaebler and Bridgewater). Significant numbers of staff were reallocated to new and different positions. Each hospital handled staffing issues in a different way.

Many state employees working in state hospitals were transferred to other state facilities or to community programs following the closing of the hospital. Often, staff were transferred with patients to other facilities, providing direct care for those patients in the new setting. Some staff were redeployed to community settings with different client populations and new treatment philosophies. A variety of different procedures were used at different hospitals to place staff into new positions and meet their needs. In all instances of redeployment, issues of staff adjustment to a new work environment are important to consider in measuring the success of staff reallocation following the closing of a state hospital.

D. MAJOR STAFFING REALLOCATIONS IN MASSACHUSETTS

In the following sections, each facility closing and the associated policies and procedures are reviewed in some detail. In addition, several staff movement activities not associated with actual closings are described. Measures of the success of the various redeployment efforts are presented. Generalizations and conclusions are drawn. Finally, a paper is presented which is intended to be a "how-to manual" for facility closings.

The case studies presented are briefly described below.

1. GRAFTON STATE HOSPITAL

Grafton State Hospital was the first facility to be closed in Massachusetts. The phase-out of Grafton State Hospital took place over a one and a half year period from February 1972 until September 1973 and involved 587 staff. Most of the staff either went to other state mental hospitals or Shrewsbury State School. A few went to the Valley Adult Counseling service and 113 remained at Grafton for maintenance purposes.

Further details of the transfers and procedures involved are given later in this paper.

2. FOXBORO STATE HOSPITAL

Foxboro State Hospital was closed in 1975. The phase-out of Foxboro lasted four months, in sharp contrast to Grafton's one-and-a-half year phase-out. The redeployment rules used at Foxboro were identical to those used at Grafton. Over two hundred of the 418 employees of Foxboro were transferred to Taunton State Hospital along with Foxboro clients to establish the Brockton and Attleboro Catchment Area units there. Over 120 employees resigned or retired. Twenty-five employees were reassigned to the Brockton Multi-service Center, and 5 remained at Foxboro to complete the closing.

3. GARDNER STATE HOSPITAL

Gardner State Hospital was closed on June 30, 1976. Although a "Blue Ribbon" Special Commission appointed by Commissioner William Goldman concluded in their final report that the hospital should not close, fiscal considerations, as well as the ideological shift in Mental Health care policy toward a community based service system, predominated and the decision was made to close.

The redeployment of staff and clients from Gardner to other facilities occurred during the hospital's six-month phase-down. For clients, two groups of patients were transferred into two hospitals to form new area units in those hospitals (32 to form the Fitchburg-Leominster unit at Worcester State Hospital, and 108 to form the Gardner-Athol unit at Rutlund Public Hospital). 200 employees were transferred to these hospitals to provide direct care for clients. In addition, many Gardner staff retired.

4. BOSTON STATE HOSPITAL

In 1981, following extensive community mental health center construction in the Boston area, Boston State Hospital was phased out, and services of the hospital were reconsolidated into fewer buildings on the campus. The reconsolidation of services involved the transfer of the hospital's inpatient unit, the Tufts/Bay Cove unit, to Lemuel Shattuck, a Department of Public Health hospital. The remaining inpatient services on the campus were split into two units: the Dorchester Unit and the West-Ros-Park unit. The Dorchester unit remained on the campus of Boston State Hospital , while the West-Ros-Park unit was located off the campus but nearby.

Fifty-five new state positions were created for the direct care of patients in the new Tufts Bay Cove unit at Shattuck hospital. All hiring in District VI was frozen so that Boston state hospital hospital staff could have first opportunity to apply for these jobs. Actual redeployment of staff was minimal.

5. REDEPLOYMENT OF WORCESTER STATE HOSPITAL STAFF TO COMMUNITY

Worcester State Hospital, like the others in Massachusetts, experienced a shift in its staffing and positions from the hospital to the developing community programs. Because of its prominence in the literature, the historical quality of its staff and their impact on treatment approaches, and the available literature, it is an interesting and worthwhile case study of the staff transfer process.

Between 1969 and 1977, the state hospitals underwent a radical shift in patient care, from the centralized hospital to a series of relatively decentralized community facilities. Staff were reassigned from hospital positions in which they had daily contact with patients and supervisors, with well defined job descriptions and easily identified lines of authority, into nonmedical situations, such as storefronts, apartments, and church

basements. These changes are documented thoroughly at Worcester State Hospital, which is used here as a case study.

6. MOVEMENT OF STAFF FROM NORTHAMPTON STATE HOSPITAL TO THE COMMUNITY

In 1978, Massachusetts signed the Brewster vs. Dukakis Consent Decree (1978) to upgrade community services in western Massachusetts. In addition to the development of a comprehensive community service system to provide the least restrictive service alternatives, ambitious plans were made to phase down Northampton State Hospital.

From an average daily census of about 500, the census was to be reduced to 250 residents by June, 1979, and in steps to 50 by June, 1981. The reallocation of funds from the hospital was to be maximized without reducing the level of remaining services.

In fact, the hospital census did not decrease as intended, and continues to remain at about 200, despite the best efforts of the Department and the plaintiffs. By 1981, approximately 75 positions had been transferred to the community. By this time, 55 were ex-hospital employees working in community programs and the rest of the positions were either transferred while vacant or the original incumbents had resigned.

THE CASE STUDIES

GRAFTON STATE HOSPITAL

Grafton State Hospital, located in the rural communities of central Massachusetts, was the first state hospital in Massachusetts, and one of the first in the country, to be closed. Its peak census, in 1956, had reached 1,787 patients. By 1966, the census was still at 1,329, and by 1971 it was down to 833. The state was interested in closing Grafton to save money. Departmental managers wanted to close Grafton in order to promote community services. The Department of Mental Health had a great deal of experience in opening hospitals, but no guidelines to follow in closing one. Consequently, the closing was a slow process. 587 staff and 581 patients were affected by the closing.

Built in 1877, Grafton State Hospital was an ideal candidate for closing. It was originally designed as a farm colony to take the overflow of chronic patients from Worcester State Hospital. It is located only eight miles from the Worcester facility and was never an "admitting" hospital. While the staff and patients had a strong sense of identity with the facility, the facility and the clients were not a part of the community. Located in a rural setting, it was removed from the network of community programs that had been recently developing.

Grafton had been marked for closing for a long time. An Ad Hoc Committee to study the future of Grafton had been established in 1968. The State Hospital Redistricting of 1970 did not assign a Catchment Area to Grafton. In addition, the physical plant was deteriorating: the water pipes that brought in potable water from Worcester needed replacing, as did the sewage, electrical, and steam systems. The buildings needed extensive renovations. It would have cost an estimated 12 million dollars at that time to renovate Grafton.

The drive to develop community programs was well underway. The Blackstone Valley Mental Health Center had been established for that Catchment Area, and an inpatient unit for Grafton admissions was created at Worcester State Hospital. In addition, many new community programs had been created in the previous few years. The new area management staff were strong managers and very community oriented. They set about obtaining community resources from the hospital, primarily by converting vacant blocks into contract funds.

In sum, the basic reasons for deciding to close Grafton included geography, the patient census (which could be transferred to chronic care facilities elsewhere), the ability of other hospitals to pick up the beds, the need for resources to develop community programs, and the deteriorated physical plant. The timing of the Grafton closing worked out well for the newly created Shrewsbury Center, where experienced business and maintenance staff were needed.

The clients to be transferred were studied thoroughly. Many of them were "ambulatory aged," having been institutionalized for years, even decades. The "Grafton State Hospital Proposed Program Plans 1971 - 1975" contained a series of graduated work programs designed to rehabilitate institutional patients and more appropriately manage geriatric patients. The chronic patients were by and large aged and did not need vocational programs but dignified, economically feasible, self help or partial help living situations. Detailed plans were implemented for patient orientation to their new settings and gradual change in surroundings. Staff gave a great deal of support to patients before, during, and after the move.

The phase-out of the hospital occurred in five phases, from February of 1972 until September of 1973. Grafton thus represents the longest duration of any of the hospital closings. A total of 587 staff were involved in the phase-out of the hospital. 170 of these staff were transferred to other state mental hospitals. 164 staff were relocated to Shrewsbury State School, a new facility opened in 1974. 113 staff remained at Grafton for maintenance purposes. Twenty-nine employees went to the Valley Adult Counseling Service (VACS), a community program in the Blackstone Valley area. These people were intensively studied by Stein and Corman (1975).

The average Grafton employee was in his or her middle forties, had been employed at the hospital for nearly ten years, and had permanent civil service status. He or she was typically married and had been born in Grafton area or elsewhere in Massachusetts. Half did not hold a high school diploma and 11% lived on the hospital grounds during their employment.

Information at the time of closing indicated that about a fourth of the employees resigned or retired at the time of closing, 38% were transferred to two state hospitals in the vicinity of Grafton, 18% were transferred to a state school, 5% went to VACS, and 13% were either transferred to a state hospital outside the area or stayed at Grafton. Most did not change their job classification, although their actual duties may have differed.

Data about transfer preferences was available for about half of the employees. This indicated that slightly more than half of this group were transferred to the location of their choice. Those that were transferred to VACS tended to be better educated and hold higher job positions.

In this first hospital closing experience in Massachusetts, the Department proceeded slowly and cautiously. As a general principle, transfers were done gradually and patients were kept as close to home as possible. Staff transfers were based as much as possible on preferences. Efforts were made to incorporate staff preferences into redeployment decisions, through surveys,

meetings, and small group processes. Prior to redeployment, staff were surveyed to solicit their preferences for relocation. Reassignment was then made on the basis of several factors, including other hospitals' needs for staff, availability of staff with desired skills, and staff preference. A special grievance committee was set up for problems and hardship cases.

The redeployment rules were as follows. A freeze was put on all state agencies. Other hospitals notified Grafton of vacancies before any other agencies. The positions at these hospitals remained vacant until Grafton employees had a chance to apply. Applicants were selected for positions in the following order of priority: (1) among applicants with the same job classification in order of seniority and (2) among all other Grafton employees in order of seniority. Transfers were made to permanent positions if the employee could be released from Grafton. If not, the employee was appointed to the new position on a permanent basis and appointed back to Grafton temporarily. If only a temporary position was available, the employee was appointed into it on a temporary basis.

One problem that was never satisfactorily resolved was the general lack of opportunity for advancement in direct care and support positions. Typically, opportunities for appointment into a higher level position came very infrequently. Appointment of staff from another facility into vacant positions had the effect of stopping promotions in places where opportunities for advancement came very rarely. This had a strong negative effect on the morale of staff in other facilities.

The closing had a pronounced effect on the Grafton staff as well. Rumors were rampant for months. To study the effects of the closing on Grafton staff, two surveys were done.

Five months after the official announcement of the closing, a survey of 156 staff showed that one third of them did not believe the hospital would really close. In an atmosphere of rumor and uncertainty, the reasons employees gave for the closing included: troubles with the hospital administration, economic impossibility of maintaining Grafton, misguided public officials, poor care, and changing concepts of mental health. Only 10% of those surveyed made any mention of possible positive benefits of the closing. 70% of the employees indicated that they had actively postponed searching for alternative employment.

A smaller group of participants in a second survey indicated that the closing was one of the most difficult times of their lives. Many of them felt that there was a little preliminary planning on the Department's part and no community involvement. They were generally bitter about the way that they and the patients had been handled. They indicated that DMH officials were strictly business-like at meetings, treated them like statistics, and lacked credibility. They valued very highly the small groups that met to cope with the closing in a humane manner.

After redeployment had taken place, the Research Institute for Educational Problems studied the effects of the redeployment on the 29 employees who had been transferred to the Valley Adult Counseling Service (VACS) in the Blackstone Valley Area (Stein & Corman, 1975). This group was studied because they most represented the goals of the reorganization of the mental health system, having transferred into a community setting rather than another state hospital or facility.

Employees reported that they had felt a great deal of anxiety and grief during the phase-out of the hospital. The also felt that the Department had neglected to plan properly, by not developing adequate community resources and failing to educate the public. They felt that the Department should have developed phase-out plans before announcing the decision to close the hospital. In fact, a widely held perception was that DMH officials had constantly changed their minds and had provided inaccurate information. In addition, employee relocation plans were not announced until nine months after patients began to leave the hospital.

It is not surprising, then, that most employees reported that the last few months at Grafton were very stressful. Although they recognized the trend toward community-based care and felt that the closing of Grafton was a progressive move, they also reported feelings of sadness and worry about what would happen to them personally.

Their first experiences at VACS were also disappointing. The authors of the study report (p.35):

> "They felt overwhelmed by the ambiguity and lack of structure. While ideologically agreeing with the philosophy of self-responsibility and group decisions, people were threatened by a sudden removal of structure and predictability in their lives..."

However, after the initial fear and anxiety, most employees reported that they liked their new jobs better than the ones they had had at the hospital. They felt that they had been given more responsibility at VACS and that their skills were being used more effectively. Many felt they had grown a great deal since working at VACS.

At the time of follow-up, the VACS group fared well. While half of them reported suffering hardships (mainly due to disruptions in personal relationships), 76% indicated that their present jobs turned out better than the one they held at Grafton. They indicated that their work changed from routinized care and support roles to more actively counseling and helping clients. They indicated satisfaction with the training and supervision they received during the transition.

During interviews, the VACS group members indicated their sadness at the closing of Grafton, and their anxiety and stress during the final months. They also indicated a more positive attitude about the impending changes than the majority of Grafton staff. Early days at VACS presented dramatic changes. Instead of the controlled, routinized hospital environment, VACS appeared ambiguous and lacking in structure. Many went through initial periods of self doubt and confusion. However, as these feelings were worked out, many also indicated feelings of positive self growth and development, the improvement of relationships outside of work, the feeling of liberation from limited goals. Over time, the sense of enthusiasm was replaced by a sober sense of satisfaction and realistic accomplishment.

The twenty-nine employees reallocated to VACS were, on the average, more motivated and open to change. Yet even they were at first overwhelmed by anxiety and disorientation upon being placed in dramatically different work surroundings with new expectations. Most of them recommended a more gradual transition from the structured atmosphere of the hospital to the more open atmosphere of VACS. However, none of them indicated a preference for the old hospital setting.

FOXBORO STATE HOSPITAL

Foxborough State Hospital was established in 1893 for the "Treatment of Dipsomaniacs, Inebriates, and those persons addicted to the intemperate use of spiritous liquors." In 1905, the legislature changed the name to Foxboro State Hospital and established a unit for the insane. Over the years, the unit for inebriates became absorbed into the main hospital for the insane and the primary diagnosis of inebriate faded out. In 1910, land was purchased in the town of Norfolk and a colony was established there as a branch of Foxborough State Hospital. In 1914, this colony became a separate facility, Norfolk State Hospital, and all male inebriates were moved there. In 1915, special facilities for women alcoholics and drug addicts were established at Westborough State Hospital. By 1918, private hospitals were licensed to treat this group and they were removed from Westborough. The Norfolk facility was discontinued for this type of patient in 1919 and was leased to the United States Government.

Foxboro had a peak census in 1955 of 1,317 patients. By 1966 the census had been reduced to 1,083, and by 1971 it had dropped to 634.

Foxboro State Hospital was closed in 1975. While the Foxboro facility was more structurally sound and more active than the Grafton facility, it too required expensive repairs. In addition, its proximity to other state facilities at a time of institutional phase-down marked its days. Foxboro State Hospital had 377 patients and 418 staff.

Foxboro was closed in four months, in sharp contrast to Grafton's one-and-a-half year phase-out. The news release announcing the close was dated July 3, 1975, and the hospital was closed on October 31, 1975.

Most patients were transferred to Area inpatient units established at nearby Taunton State Hospital for the Brockton and Attleboro Areas. This required reducing the existing census and then moving both patients and staff to the new facilities. Smaller numbers of patients were transferred to facilities where they held meaningful Area ties.

Although the redeployment rules used at Foxboro were identical to those used at Grafton, there was no formal solicitation of staff preferences for relocation. Employees could apply to transfer to another facility, either through transfer of the employee and his/her block, or through vacating the Foxboro block and transferring into a vacant block at another facility. These transfers were determined to be a critical need by the Department of Mental Health and the Executive Office of Administration and Finance, in order to avoid certification and verification of each transfer request and meet the October 31 deadline.

Vacancies to be filled were posted at Foxboro State Hospital, and employees made application to the appointing authority where the vacancy existed. Employees were considered first who were in the same classification as that of the vacancy, and second from anywhere else in the hospital.

Over two hundred of the 418 employees of Foxboro were transferred to Taunton State Hospital along with Foxboro clients to establish the Brockton and Attleboro Catchment Area units there. Over 120 employees resigned or retired. Twenty-five employees were reassigned to the Brockton Multi-service Center, and 5 remained at Foxboro to complete the closing. Smaller numbers transferred to vacancies in other state facilities in Massachusetts.

Employees attitudes toward the closing were studied by the Department (Markson & Yaskin, 1976). The vast majority of staff did not want the hospital to close. Moreover, there were considerable bad feelings among the staff who responded to the survey and met with interviewers.

Fifty-two percent of the respondents believed the reasons for the closing as given by the state. However, only 25% believed that the patient transfer process was well handled, and 52% felt that it was badly managed. However, when asked about staff transfers, one third of the respondents thought they were well handled, one third thought they were poorly handled, and one third had no comment. Forty-nine percent indicated negative feelings toward state emplyment and the Department of Mental Health as a result of the closing.

GARDNER STATE HOSPITAL

Gardner State Hospital was established in 1902 as an overflow colony for Worcester State Hospital. It was closed on June 30, 1976. Like Grafton, its origins as a colony gave the facility particular characteristics that contributed to its closing. The majority of patients were chronic, and could be transferred to long term Public Health facilities. In addition, it did not have the close ties to the community and the emerging community service system that a historical hospital facility had.

The census at Gardner had reached 1,335 in 1955. By 1966 it was 988, and by 1971 it was 854.

In addition, the physical plant was old and deteriorated. The Gardner facility had been decertified and had no reimbursable beds. It needed substantial repairs to the physical plant, and the inpatient census was low. The Gardner facility was located within 25 miles of the Worcester State Hospital, and close to the Rutland Heights chronic care facility, operated by the Department of Public Health. In addition, there were several other state agencies and Departments within the Gardner State Hospital area. At the time of closing, there were 250 patients and 407 staff.

The hospital was closed in six months. The closing of Gardner represented considerable fiscal savings, since the hospital had an annual (FY76) budget of about $5 million dollars.

A "Blue Ribbon" Special Commission was appointed in 1974 by Commissioner William Goldman to study the future of the Gardner facility. This special commission concluded in their May, 1975 final report that the hospital should not close. They stated that there was a continuing need for 75 secure beds for acute cases in that area, as well as 175 beds for chronic cases. However, the fiscal considerations, as well as the ideological shift in Mental Health care policy toward a community based service system, predominated and the decision was made to close.

The redeployment of staff and clients from Gardner to other facilities occurred during the hospital's six-month phase-down. For clients, two groups of patients were transferred into two hospitals to form new area units in those hospitals (32 to form the Fitchburg-Leominster unit at Worcester State Hospital, and 108 to form the Gardner-Athol unit at Rutlund Public Hospital). Most of the Gardner employees were transferred to these hospitals to provide direct care for clients. In addition, many Gardner staff retired. Thus, there was not an extensive amount of staff redeployment activity in the case of the Gardner closing.

However, staff changes were more difficult than in the cases of the other closings. The Gardner area is relatively remote and more economically depressed. Therefore, new staffing assignments

that did not involve additional travel time and expense were rare.

Markson and Yaskin (1976) studied this group of employees also. They found that staff feelings were much more negative and hostile in this group. The response rate to their survey was only nine percent. Moreover, in their interviews with staff, they found a pervasive attitude of being leery of participation. 30% made pointedly hostile and rude comments on the survey forms, and another 30% made somewhat hostile comments. Twenty five percent were neutral, and only 15% made positive statements.

Only one third of the respondents believed the reasons for closing as given by the state. Moreover, there had been rumors of the closing for years, so that staff moral was already at a low point when the actual announcement was finally made. As a result, although 43% indicated negative feelings toward state employments and the Department, it did not seem to be increased as a result of the closing. Staff were already negatively inclined toward the Department.

Perhaps because the patient transfers had occurred over a longer period of time, 48% of the staff indicated that the patient transfer process was well handled. The feelings toward the transfer process for staff members were the same as among the Foxborough staff.

Major topics for discussion were the feelings of bewilderment, anger and disappointment of the staff. They saw Central Office as not communicating openly about the closing process and not allowing input in the process. There was even anger expressed at the idea of doing a study of the closing. One psychiatrist called it a waste of money that should be used to keep the hospital open.

Almost universally, staff felt that patient care was good and that they were not appreciated. The reasons for the closing were often seen as Central Office caring only about money and politics, while the patients and community were being hurt by the closing. Many felt that staff were getting bad deals on the new jobs: family routines were disrupted, more travel was involved, and the new shifts were inconvenient.

BOSTON STATE HOSPITAL

Boston State Hospital was established as the Boston Lunatic Hospital in 1839. As noted above, this was the nation's first municipal mental hospital. It was also the twelfth psychiatric hospital to be founded. Originally consisting of one building on five acres of grounds, the hospital in its first year of operation treated 104 patients with one doctor and a dozen staff.

The original site of the Boston Lunatic Asylum was what is now known as South Boston. At the time of its construction, the area was a natural place to develop the new hospital. The area was undeveloped, so the city moved its houses for prisoners and paupers there (when the area was annexed in 1805, only ten families lived in "Dorchester Neck"). The new state law which led to the construction of the hospital was designed to force cities to remove insane patients from the jails and poor-houses. The first 65 patients of the new facility were delivered from the two neighboring institutions, some of them hauled over by carts on which they had been confined in wooden cages.

The first superintendent, Dr. John S. Butler, was one of the great early psychiatrists and set up a program of humane care which seems modern today. He eliminated restraints as far as possible, developed programs of work and recreation, ate and worshipped with his patients, and believed in the curability of each man and woman under his care.

However, as time passed, conditions became increasingly difficult. The hospital became more crowded and was limited from expansion by its now urbanized neighborhood. By 1846, only seven years after the hospital opened, there were 104 patients in a space intended for 66. Quiet patients lived in the attic. By 1852, agitation began to move to a farm in the suburbs. However, actions to do so were postponed by the outbreak of the civil war.

In 1873, the city purchased the 47 acre Austin Farm in Dorchester for 5 cents a foot and constructed facilities for a "poor farm." In 1884, 84 mentally ill women were moved from South Boston to these facilities.

The city bought the 37 acre Pierce Farm in West Roxbury for $34,500 in 1892 and 48 acres from the Forest Hills Cemetery in 1893 for $23,000, and constructed physical facilities there. In addition, it built additional buildings on the nearby Austin Farm. In its final location, the hospital eventually grew to 54 buildings on over 232 acres, with more than 1,000 staff and 3,000 patients.

The peak census was 3,081 in 1953. This had dropped to 1,610 in 1966 and to 797 in 1971.

By 1981, Boston had constructed a series of community mental health centers which substantially reduced the inpatient census at Boston State. The decision was made to phase out the remaining facilities by consolidating them into fewer buildings on the campus and two areas: the West-Ros-Park Mental Health Center and the Dorchester Community Mental Health Center. At that time, Boston State had 631 staff.

The reconsolidation of services involved the transfer of the Tufts/Bay Cove inpatient unit, to Lemuel Shattuck Hospital, a Department of Public Health facility. The remaining inpatient services on the campus were split into two units: the Dorchester Unit and the West-Ros-Park unit. The Dorchester unit remained on the campus of Boston State Hospital , while the West-Ros-Park unit was located off the campus but nearby.

Fifty-five new state positions were created for the direct care of patients in the new Tufts Bay Cove unit at Shattuck hospital. All hiring in District VI was frozen so that Boston state hospital staff could have first opportunity to apply for these jobs. Actual redeployment of staff into new job situtations was minimal.

REDEPLOYMENT OF WORCESTER STATE HOSPITAL STAFF TO COMMUNITY

The State Lunatic Hospital at Worcester accepted its first patient on January 19, 1833. It was the first public hospital in Massachusetts, the first state hospital in New England, and the seventh state hospital in the United States. It was the first state institution that relied on moral treatment. The first superintendent was Dr. Samuel B. Woodward, who was one of the founding fathers and the first president of a national society of medical men that was to become the American Psychiatric Association.

The first hospital building for 120 patients and the addition of two wings for 100 more patients in 1836 were largely due to the influence of the "Father of Worcester State Hospital," Horace Mann, the prominent Boston educator and legislator. In 1844, the hospital was expanded to accommodate 400 patients due in part to the efforts of Dorthea Dix. It should be noted that Dr. Woodward strenuously protested the enlargement, realizing that it would destroy the close staff/patient relationships that were the cornerstone of Moral Therapy. He preferred the construction of a larger number of smaller institutions.

Worcester State Hospital has played an important role in the history of treatment for the mentally ill. It served as a proving ground for the Moral Treatment concepts and proved that recovery could be the rule. Some of the most famous and distinguished names in psychiatry and medicine, such as Adolph Meyer, made fundamental contributions at Worcester. Until overcrowding and expansion beyond optimum size disrupted the vital interactions among patients, staff, and psychiatrists, detailed statistical records were kept.

However, as in all state hospitals, the mental hospital living standards deteriorated throughout the latter part of the nineteenth century. By 1953, the inpatient census of the hospital had risen to 2,777. By 1966, it had decreased to 1,083, and by 1971 to 736.

David Myerson, who was appointed both Medical Superintendent of Worcester State Hospital and the Greater Worcester Area Director, has extensively described the process of redeployment from 1969 to 1977 (Morrissey, Goldman, & Klerman, 1980).

Worcester State Hospital was not given additional funds to develop community programs. Instead, Area Directors were told to take funds from their portions of the Worcester State Hospital budget to set up aftercare programs. Myerson wrote:

> "Repeatedly, I was confronted with difficult choices, as for example, whether I should assign a nurse to a community clinic in Worcester or or to an inpatient ward of the Worcester State Hospital unit serving the Greater Worcester

Area. Initially...I thought that if circumstances dictated I could reverse these staff assignments at a later date. My naivete in this regard became evident on several occasions when I attempted to pull back ward staff assigned to community groups in the Greater Worcester Area, only to encounter the outrage of community groups protective of "their staff."... My conflicts over staff assignments with other Area Directors were far more serious from the outset. Here there was no question that, once assigned, staff positions could never be called back to meet mounting demands on the admission wards at Worcester State Hospital."

Programs were developed with resources taken from Worcester State Hospital as well as by pooling resources with other non-profit organizations.

The multitude of different agencies involved created inevitable problems. Medically trained hospital staff had difficulty working in more informal environments in the community. Lines of authority were also confusing. Hospital staff working in the community were responsible to the clinical director of the program, instead of the hospital superintendent, an agreement that was both unpopular and repeatedly questioned. Because of strict union rules, however, the clinical director could not fire state workers. Thus, it was up to the superintendent to reassign employees with whose work a clinical director was not satisfied.

Community positions were also difficult to fill. For the hospital staff, community work was generally viewed as unpleasant, and it created a problem in filling community assignments. Social workers and psychologists generally found the new work more acceptable than medically trained professionals. In 1973, a survey sent to all hospital personnel assigned to state programs showed that the vast majority of them retained a strong sense of identity with the hospital.

Eventually, three recruitment techniques were used to fill the mushrooming community positions using hospital resources:

1. Recruiting those who bid for the positions.

There was a small group of personnel from different disciplines who preferred to work in the informal community settings rather than the closely supervised wards.

2. Establishment of training programs.

Using the local unions and colleges, training in community psychiatry was set up for mental health assistants and nurses. Participants received academic credits and, in some cases, minor salary upgradings.

However, despite the fact that the courses were well received and popular, the staff greatly preferred the traditional

hospital setting. Only 8 of 50 MHA's went into community programs. When a new community oriented program needed five nurses, only one bid for a position. It was necessary to recruit the others from outside.

3. Assignment of unfilled positions.

Vacant blocks (unfilled positions) were assigned to programs. The administrator of the program was authorized to hire the personnel and provide the training, while Worcester State Hospital paid the salary.

Eventually, the state adopted the policy of converting funding from state staff to contract for services. The intent was that this mechanism would provide more flexible program development and a higher degree of accountability.

MOVEMENT OF STAFF FROM NORTHAMPTON STATE HOSPITAL TO THE COMMUNITY

Northampton State Hospital is located in the city of Northampton, Massachusetts, which has a population of 30,000 and is 17 miles from the major industrial city of Springfield. It serves the four western counties of the state, which are predominantly rural. The hospital is within walking distance of the main street of town and adjoins the grounds of Smith College. About 75 percent of the hospital employees live in the city, and almost half were born in the county. The hospital was built in 1858 during the "Moral Treatment" era and has been through the changes described since that time.

The Northampton Lunatic Hospital was the third state hospital to be built in Massachusetts. By that time, the existing hospitals at Worcester and Taunton had become seriously overcrowded, the population in western part of the state had steadily increased, and improved transportation had made this part of the state more accessible. In October, 1855, 172 acres of land were purchased for $13,000. Construction was completed in the spring of 1858, at a cost of about $300,000.

The hospital was built in the "Kirkbride" style (after Dr. Thomas Kirkbride at the Pennsylvania State Hospital in Philadelphia) and consisted of one large building, as opposed to the Gheel, or cottage type of institution. The main building was 512 feet long and was surmounted by a cupola "in which is an observatory from which the most magnificent prospect in the Connecticut Valley can be obtained."

The first patient, a woman, was admitted on July 1, 1858. By October 1 of that year, 220 patients had been admitted, five-sixths of the number originally planned for. Superintendent William Henry Prince was assisted by five trustees and five salaried employees - an assistant physician, a clerk, a treasurer, an engineer, and a farmer.

From 1872 to 1892, the hospital census remained fairly constant at 469. Then the census rose steadily until 1903, when it reached 657. New infirmaries for men and women were constructed to ease the overcrowded conditions, and the patient population continued to increase. By 1928, Northampton State Hospital had grown to 1559 patients and 219 employees, and substantial construction was undertaken to provide adequate facilities.

By 1952, there were 2,331 patients and 509 employees, and a number of important client oriented programs and services, with significant volunteer programs and medical services. The peak census was 2,364 in 1955. This decreased to 1,919 in 1966, and to 1,424 in 1971.

In 1978, Massachusetts signed the Brewster vs. Dukakis Consent Decree to upgrade community services in western Massachusetts. In addition to the development of a comprehensive community service system to provide the least restrictive service alternatives, ambitious plans were made to phase down Northampton State Hospital.

From an average daily census of about 500, the census was to be reduced to 250 residents by June, 2979, and in steps to 50 by June, 1981. The reallocation of funds from the hospital was to be maximized without reducing the level of remaining services.

In fact, the hospital census did not decrease as intended, and continues to remain at about 200, despite the best efforts of the Department and the plaintiffs. Consequently, relatively few numbers of staff have left the hospital. However, the rapid expansion of the community service system and the shift in service ideology from centralized institutional based services to a community services model created an opportunity structure for staff to move on a voluntary basis to different job settings. Because of the visibility and interest in the Consent Decree, these staff have been well studied. Therefore, it is instructive to look at the experiences of these employees in relation to those being reallocated as a result of real phase-down and closings.

By 1981, approximately 75 positions had been transferred to the community. By this time, 55 were ex-hospital employees working in community programs and the rest of the positions were either transferred while vacant or the original incumbents had resigned. The Western Mass Training Consortium conducted an in-depth study of the experiences of these people. They contacted 42 ex-Northampton State Hospital employees who left the hospital and were in state positions in community programs at that time.

The survey found the following conclusions:

1. Satisfaction: employees were more satisfied with their work in the community relative to work in the hospital. 80% were "much more" or "more" satisfied and none were less satisfied.

2. Type of work: most employees were working in standard positions with regular workweeks, performing service coordination, client assessment, crisis, vocational or day activities.

3. Problems: Slightly more than half indicated experiencing problems in moving into the community. However, the problems they indicated were not the expected problems related to attitudes of employers and non-state co-workers, but were more job related issues, such as attitudes of other agencies, reimbursement for travel, travel time, lack of skills to do the work, etc.

4. Orientation: 57% of the employees had received an orientation. In general, the employees indicated needs for orientation in (1) seeing the programs before starting work there, (2) receiving specific information about what would be needed for the new position, and (3) on-the-job-training when moving into the new position.

This group of employees was more educated relative to the hospital as a whole. Over two-thirds held a "2-year" certificate or more as compared to one third of the overall hospital employees, and only nine had a high school education or less. Most of the group were direct care positions (MHA I - III) (45%), clinical positions (24%), and nursing positions (26%). There were no employees from clerical, trades, dietary, or administrative positions.

All but two of the group wanted to leave the hospital and left through a voluntary transfer or promotion. The most usual reasons expressed were wanted to get into community work or wanting to leave the conditions of the hospital.

Nearly all employees had recommendations for improving the transition process. Most frequently mentioned was getting a clear understanding of the job and program where one will be working. This encompassed a variety of techniques: education, clear expectations, visiting the job site, working alongside a more experienced co-worker, etc.).

Also mentioned was education in the knowledge of the different agencies, area resources and area characteristics where they will be working.

Understanding clients needs and responsibilities in the community, and techniques for developing positive attitudes and empathy toward clients was frequently mentioned. Also, employees indicated the need for having more support in the initial stages of moving into the new position.

The employees noted that work in community settings is fundamentally different from working in a hospital setting. Instead of being highly structured and routinized, community work tends to be more hectic and less structured. Consequently, employees frequently need preparation and assistance in making the transition into very different working environments characterized by different types of relationships with clients and peers.

SECTION II: GENERALIZATIONS

In this section, a series of generalizations drawn from the the case studies of Section One are developed. While each case study is based on a unique historical event, it is important to examine the similarities and common features among them. By doing this, potentially valuable insights and lessons can be learned from the experience of Massachusetts that may be useful for other states.

Again, it is important to consider that this is a historical review of events that took place some time ago. Massachusetts has moved since that time to adopt a new service system perspective which revitalizes the role of the state hospital. At the time of the closings, there were intensive Departmental efforts at several management levels to scale down the institutions and shift the resources to community services.

The Department has since reaffirmed the necessity of inpatient care for some clients, and has taken definitive steps to improve the quality of the inpatient environments by adding staff and resources back to the hospitals. Massachusetts is not returning to the days of large scale institutions, but is committed to a balanced service system which includes both inpatient and community services. This is requiring substantial capital as well as operational costs because of the deteriorated condition of the hospitals.

The generalizations are made according to the following set of major categories.

I. DECISIONS ABOUT WHICH HOSPITALS TO CLOSE

In Massachusetts, hospitals were not selected randomly for closing or phase downs. While some unique factors were in operation, such as the strength of individual managers, some basic rules operated to predispose certain institutions for closing, such as level of physical deterioration and cost of repairs, proportion of chronic patients who could be moved to other long term care facilities, and proximity of other inpatient units to serve area needs.

1. More geographically remote facilities pose larger staffing problems - distance to new work sites, lack of suitable employment alternatives, poorer local economies, etc.

2. Given the inevitable need to relocate patients into other structured settings, facilities with geriatric and infirm patients which can be moved to chronic care facilities will be the most likely targets for closing or phase downs.

3. Local communities are very resistant to closing an institution, since jobs and population will be lost.

Two of the institutions closed in Massachusetts were established as colonies. As a result, they had an older, more chronic patient census and did not have the close ties to the community service system. It was relatively easier to transfer groups of chronic patients to long term care facilities in these instances. In all cases, staff reallocation was heavily dependent on the availability of other state employment possibilities and the local economies.

II. DETERMINING HOW MANY BEDS ARE NEEDED

Estimations of the number of people needing inpatient services is the key data required in determining how many beds should be available to meet community needs. Historically, the decisions to close hospitals generally followed assumptions that nearly all inpatient beds could be eliminated. In fact, that did not happen, and the results were manifested in insufficient resources following the movement of clients to other inpatient settings. Insufficient resources were moved to the community to develop that system as well.

1. If unrealistic projections of census reduction are used to drive reallocation of hospital resources, and are not achieved, remaining patients may suffer as a result of the reduced resources available to meet patient needs.

2. It is extremely unlikely that a hospital census can be deinstitutionalized to zero. This fact will drive hard decisions on where to place patients and how many and which staff to move with them.

3. In nearly every case, hospital census was reduced during the preceding years to a smaller core group of patients who were not suitable for community placement, In spite of a strong commitment of the area directors to community services, this core group had to be transferred to other inpatient settings.

4. The redistribution of resources was very difficult to make equitably. Generally, area managers did not receive as many resources as they had expected. At the same time, hospitals were further depleted, and the potential for client underservice increased.

5. Gross measures of commitment to hospital treatment, such as dollars per capita, do not tell important facts about the quality of inpatient care, such as staff/client ratios, available treatment milieus, physical plant adequacy, etc.

6. The initial stages of deinstitutionalization were characterized by ideological conflicts around hospital versus community treatment. These conflicts were uncomfortable for many people and polarized many professional and citizen groups. In order to achieve maximum service system development and continuity of care among a range of services, these conflicts must be reconciled. It is critically important to recognize the need for an appropriate balance among all service modalities, including inpatient treatment, and plan an array of services operating cooperatively.

Massachusetts had a strong commitment to the treatment philosophy of deinstitutionalization and successfully placed large numbers of patients into community programs. However, it was never able to reduce the inpatient census below a certain point (about 2,200) and was never able to entirely reduce the census of any inpatient unit to zero.

As a result, large numbers of clients had to be moved, and staff resources with them. As a result, the community managers never received the resources they expected, and the other hospitals never received staff resources commensurate with the extra patient load.

III. EFFECTS OF REALLOCATION ON STAFF:

1. AFFECTIVE REACTIONS

Closing a hospital has a disastrous impact on staff, for a variety of reasons. In addition to the simple issues of the threat of job loss, unknown new working conditions, disruptions of life routines, and so forth, direct care human service work is characterized by strong relationships between staff, patients, and the environment. Closing an institution violates these relationships and places an aura of uncertainty over the job functions and employment of each staff person.

1. Staff will generally have negative emotional reactions to a closing or phase down.

2. Reallocation/closing is a traumatic experience. Even for staff who are highly motivated toward community work, the changes represent significant disruptions and create stress.

2. STAFF PERCEPTIONS

Staff are personally affected by the closing and reallocation process. As such, they will develop their own perceptions, definitions of situations, and attributions of causes. If ignored, staff morale can be severely damaged and long standing problems with the workforce may result.

1. Throughout the process, staff express a primary concern with the welfare of the patients. Many reasons expressed against a closing are in terms of the adverse effects on the patients.

2. Staff generally perceive the hospital as a good and effective environment for clients, and have positive perceptions of their role in patient care.

3. Staff have a strong orientation to the facility and clients. Closing or major phase downs are seen as threatening and destructive.

4. New staff going as a group tend to identify themselves according to their old institutional ties, and be identified by the existing staff as outsiders from the old institutions. These identifications can be remarkably strong.

3. LINES OF COMMUNICATION

One of the most important things the Department can do during a major reallocation project is to develop open lines of communication with staff. Without direct communication, the perceived threat of the situation will lead to strongly negative attributions and poor morale.

1. During a closing or major phase down, management is generally viewed with skepticism, disapproval, and often outright hostility.

2. Movement toward closing without communication with line staff creates an environment of confusion, negativism, rumors, and poor morale.

4. STAFF ORIENTATION AND TRAINING

Clearly, orientation and training for new job roles and opportunities are critically important. However, they should not been seen as a panacea for all reallocation problems. Management must understand the importance, and the limitations, of orientation and training for staff.

1. Staff generally report a desire for orientation and training regarding new service roles and expectations. A phase-in plan, allowing new staff to work side by side with existing community staff, or a mentor system, would appear to be very promising and warrant serious consideration.

2. The differences between inpatient and community work appear to be significant enough that training programs alone are not sufficient to allow staff to comfortably make the transition.

5. DIFFERENCES IN WORK ENVIRONMENT

There are important differences in the work environment between inpatient and community settings. Staff trained and experienced in the structured hospital setting should not be expected to go directly into the unstructured and often ambiguous roles encountered in community work. These differences, as well as the basic issues of distance to work, shift availability, etc, can cause great stress even in staff motivated to make the transition.

1. Hospital staff are frequently very involved in community work and affairs.

2. New community work settings are significantly different from hospital settings, in terms of clarity of lines of authority, routinization of rules, clarity of treatment setting, medical orientation of treatment environments, expected patient/staff roles, and degree of structure. Staff need orientation and training in order to make this transition.

3. Only a relatively small proportion of staff in a hospital will volunteer to be reallocated to community positions.

4. Staff need to be able to see the continuity between workplace environments. Such techniques as common information forms and information systems could be valuable aids in assisting staff to adapt to new work locations.

6. STAFF ADJUSTMENT TO CHANGES IN WORK SETTINGS

Virtually all staff will experience stress associated with reallocation. In time, staff will adjust to their new settings. However, that process can be long and painful, or it can be shortened by management attention to several basic details.

1. Staff concerns during redeployment tend to be highly pragmatic. Travel time to new locations, shift availability, maintenance or disruption of social relationships are important considerations.

2. For staff with strong motivation, orientation and training, adjustment to new work settings will occur.

3. For facility based employment, opportunities for advancement are infrequent. Staffing reallocations will impact this and may create hard feelings for years to come.

4. Important determinants of the perceived adequacy of staff and client transfers are:
   1. the amount of patient census reduction to date, and
   2. the amount of time available to plan.

Staff are not passive in the reallocation process. Indeed, their lives and careers are directly changed as a result. As such, their primary orientation to the process is likely to focus on the potential negative outcomes for themselves and the treatment system.

Most staff do not readily embrace the reallocation to the community. In fact, the differences in working environments is marked enough that even highly motivated staff go through a period of adjustment. In short, most hospital staff seem to prefer working in the hospital environment, and orientation and training alone is not sufficient to make the transfer easy.

In Massachusetts, by far the largest number of positions transferred to the community were done through the reallocation of vacant blocks. Most actual staff transfers were to other inpatient settings.

SECTION THREE: IMPLICATIONS AND LIMITATIONS

I. THE NATURE OF CHANGE IN TREATMENT PHILOSOPHIES

The treatment system is not stable over long periods of time in terms of a uniform ideology or set of treatment values. The service system and the underlying treatment values are related to large scale social, political, and economic processes, which change and develop over time. Understanding these changes in service system values is central to understanding why hospitals have received different emphases historically.

The following generalizations express the experience of Massachusetts.

1. Prevailing paradigms of treatment are not stable over long periods of time. Instead, the paradigms change over relatively short periods of time (i. e., five to ten years) .

2. It is oversimplistic to assert that changes in treatment paradigms are merely cyclical. Massachusetts is not reverting to an earlier paradigm of large scale institutional treatment. Instead, Massachusetts is developing a highly sophisticated articulation of the Balanced Service System which includes both inpatient and community services.

3. The service system should not be conceptualized in terms of community <u>or</u> hospital or, worse yet, community <u>versus</u> hospital. Instead, client care should be seen as embracing a range of treatment environments, including both inpatient and community. The appropriate emphasis should be placed on achieving continuity of care among treatment environments.

4. Traditionally, many managers and staff tend to take strong positions for or against inpatient services. The view of quality inpatient services working hand in hand with quality community services to provide a balanced array of treatment modalities appears to be a newly emerging perspective. It may take some time for the pre-existing traditional attitudes toward services to change.

5. Differences in environments between hospital and community settings are significant. It is very difficult, even with training and ongoing support, to successfully reallocate hospital staff to community programs. In the past, hospital resources have not been sufficient to adequately provide inpatient services to remaining clients as well as staff up community programs.

The historical experience of Massachusetts shows that the treatment paradigm shifted from one which emphasized the dramatic phase down of institutional treatment to one which emphasized balanced services in a relatively short period of time. In some cases, the revitalization of inpatient treatment has been confused with the return to a system of large scale institutional care. It is important to recognize that the current treatment system is not a return to previous paradigms, but the emergence of a new service system philosophy.

II. FACTORS WHICH MAY LIMIT GENERALIZATIONS:

Each state has unique factors which directly effect its ability to reallocate staff. For example, the extra travel time for staff in new job locations is not as much of a consideration in a small state as it is in a large state. Some of these factors are listed below.

1. Geography and local economy. The availability of other state positions in a reasonable distance, the ability of staff to travel to new sites, potential for other employment in the general area all have profound impact on staff. A hospital in a relatively isolated area with a poor local economy and restricted local employment opportunities will pose major problems for staff redeployment. Massachusetts is a relatively small state with a strong economy, so these considerations did not pose the same level of difficulty that they may for other states.

2. At the time of many of the Massachusetts hospital closings, a large proportion of staff were long term employees with a strong sense of identification with the clients, the facility, and the community. There may be important differences with a more transitory staff who have less time invested in the system.

3. While the case studies presented here did not go into the roles played by individuals in key positions, it is clear that individual effort was often responsible for particular outcomes. On the one hand, in addition to a clear and well developed process for achieving change, there must exist the strong support and energetic guidance of assertive management. On the other hand, the zealous efforts of well meaning individuals must be coupled with a rational planning and implementation process.

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